MEDICAL
SERVICE AND FEE SCHEDULE
MSA – 141890

The Service Fees and Services effective for the period beginning July 1, 2019 and ending December 31, 2022 are specified below. For membership that enrolls prior to January 1, 2020, the **Medical Administrative Fees Per-Employee, Per-Month (PEPM) shall be billed at the 17,500 – 25,000 tier below.** They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

For purposes of this Schedule, Aetna may be referred to using 'we', 'our' or 'us' and Customer may be referred to using 'you' or 'your'.

Self-Funded Medical Service and Fee Schedule

YEAR 1 – Per Enrolled Employee- Per-Month (fees apply to new business enrollment effective 7/1/2019 through 12/31/2020, valid through 12/31/2020, subject to the terms and conditions within the attached Medical Financial Assumptions). Note: We have reduced the first year fees by [redacted] to remove expense for covering runout at termination.

Medical Administrative Fees Per-Employee, Per-Month (PEPM)*	**Year 1 Choice POS II (Broad Network)**	**Year 1 Open Access Aetna Select (Broad Network)**	**Year 1 Aetna Whole Health New Jersey/Open Access Aetna Select (Narrow Network)****
Assumed Enrollment			

[redacted]

YEAR 2 and YEAR 3 – Per Enrolled Employee- Per-Month. Year 2 fees are effective 1/1/2021 to through 12/31/2021. Year 3 fees are effective 1/1/2022 through 12/31/2022			
Medical Administrative Fees Per-Employee, Per-Month (PEPM)*	**Years 2 & 3 Choice POS II (Broad Network)**	**Years 2 & 3 Open Access Aetna Select (Broad Network)**	**Years 2 & 3 Aetna Whole Health New Jersey/Open Access Aetna Select (Narrow Network)****
Assumed Enrollment			
[redacted]			

***The expenses associated with processing runoff claims following cancellation are not included in the fees above. If APEMT requests that Aetna process runoff claims, we will charge a fee upon cancellation. The determination of the runoff fee, which is billed upon termination, is as follows:**
Average Medical Administrative Fees PEPM fee over the last [redacted] months * the estimated average number of employees covered during the first year of your Agreement * [redacted] The PEPM fees used in this calculation are shown in the above tables.
Please note that the above referenced runoff charges will be waived if APEMT stays with Aetna through [redacted]

****We have provided a risk-share document for Aetna Whole Health New Jersey under separate cover. The risk share document provides details on risk-sharing, savings, accountable care payments and reconciliation.**

Our fees are based on the total number of employees enrolled in Aetna medical products.

Please refer to the Pricing Assumptions for a detailed description of the services, terms, and conditions associated with our self-funded proposal.

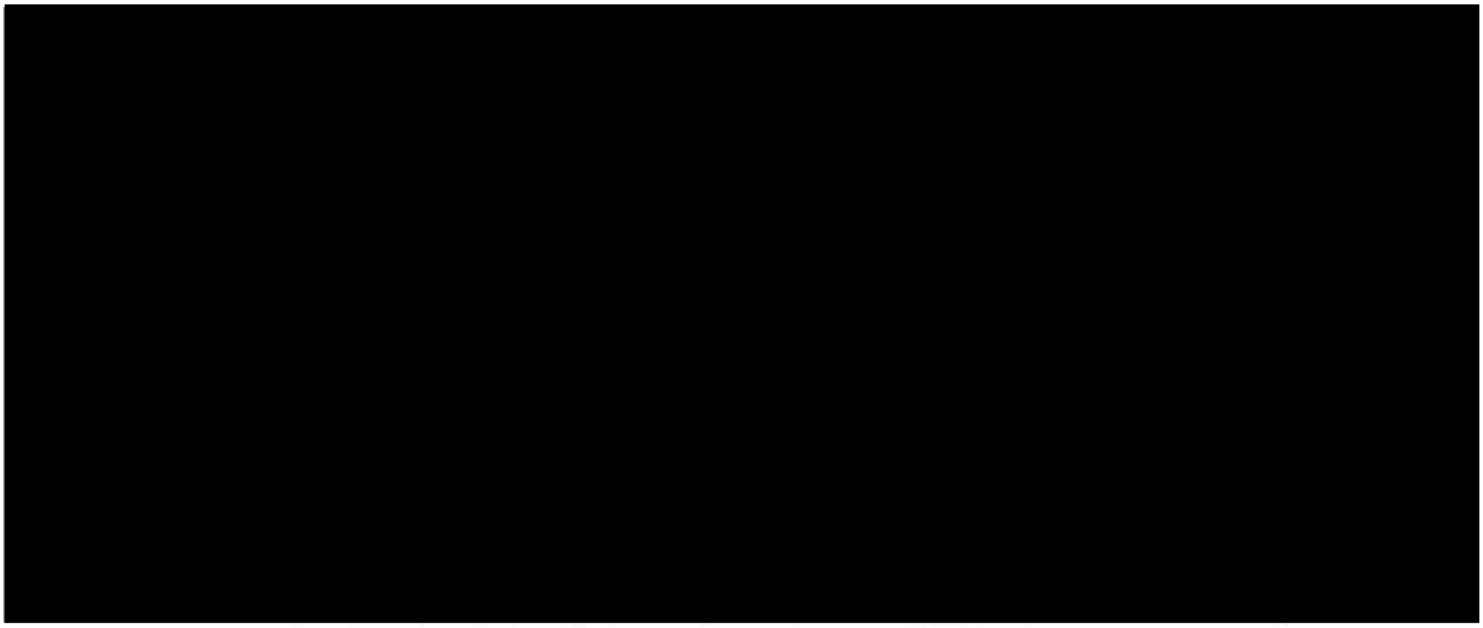
We guarantee that the second-year Medical fees will increase over the first-year Medical fees by [redacted] PEPM. We also guarantee that the third-year Medical fees will increase over the second-year Medical fees by [redacted] percent. Medical fees in years [redacted] and [redacted] will increase annually by [redacted] percent over the prior year fees. We have also included performance guarantees in this proposal.

Included Services / Programs in Above Administrative Fees	Choice POS II (Broad Network)	Open Access Aetna Select (Broad Network)	Aetna Whole Health New Jersey/Open Access Aetna Select (Narrow Network)	APEMT elected service (Yes or No)
Implementation & Communication				

[redacted]

Aetna One Advocate Member and Claim Services***				**APEMT elected service (Yes or No)**

[redacted]



Reporting				**APEMT elected service (Yes or No)**
[redacted]				

Claim Wire Billing[3] (Charged through the claim wire. Not included in Above Administrative Fees)	**Choice POS II (Broad Network)**	**Open Access Aetna Select (Broad Network)**	**Aetna Whole Health New Jersey/Open Access Aetna Select (Narrow Network)**	**APEMT elected service (Yes or No)**
[redacted]				

[redacted]

Optional Buy-Up Services / Programs (per-employee, per month fees (unless otherwise noted) that would be in addition to the above Administrative Fees) The percentages and fees below shall apply without change to the Initial Term:	Choice POS II (Broad Network)	Open Access Aetna Select (Broad Network)	Aetna Whole Health New Jersey/Open Access Aetna Select (Narrow Network)	APEMT elected service (Yes or No)
General Administration				

[redacted]

[1]Teladoc - In addition to the administrative fees as outlined above, the following per Teladoc claim consult charges are collected through the claim wire.

[redacted] for General Medical Services
[redacted] for the first Behavioral Health consultation with a psychiatrist
[redacted] for all subsequent Behavioral Health consultations with a psychiatrist; and
[redacted] for each Behavioral Health consultation with a Masters level therapist other than a psychiatrist
[redacted] for Dermatology
[redacted] for Caregiver (paid directly to Teladoc at the time of visit)

[2] Member Engagement Platform includes: health assessment (online and mobile), online digital coaching, member health record, care engine, member messaging.

[3] Claim wire billing fees refers to the portion of the total administrative expenses that are charged through the claim wire as the services are rendered. Expenses that are charged through the claim wire include those described on the Fee Schedule as well as those fees that the parties may subsequently agree to add to the claim wire from time to time. Programs/services that are charged through the claim wire are excluded from the monthly PEPM Administrative Fees as illustrated above and will not appear on the monthly billing statement for PEPM Administrative Fees, but will appear in other monthly reports provided to the customer.

[4]COB administration and screening is included at no additional charge as part of our standard claim adjudication process. Aetna also uses suppliers to support COB recovery through their analytics and algorithms that identify, validate, and collect COB related overpayments; it is only the recoveries achieved by the suppliers that are subject to the percent of savings administrative fee charged to the customer (named below). Aetna utilizes external vendors for claim recovery on: Payer liability (e.g. member eligibility verification, COB), Coding compliance (e.g. payment policy adherence, duplicate claims), Contract compliance (e.g. provider contract adherence), Clinical appropriateness (e.g. clinical feasibility and appropriateness of claim, chart review verification of claim), Coordination of Benefits (primary and secondary review), Retroactive Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation (California, Florida, New York, Ohio and Texas), DRG and Implant Audits. A contingency fee of [redacted] is charged for said claim recoveries. These fees are primarily to support vendor costs and Aetna's internal administrative costs associated with these programs.

[5]This buy-up option provides flexibility to tier benefits, offering different levels of co-insurance and shifting out of pocket costs to the member when IOQs are not utilized thus encouraging use of IOQs. Members will have a higher benefit when selecting care at a facility designated as an IOQ. It is this benefit differential enhancement for which we will apply a charge.

****The following services may be carved-out in the future at APEMT's discretion at a mutually agreed upon fee reduction:

Teladoc, Aetna One Advocate, Enhanced Clinical Review, Managed Behavioral Health including Behavioral Health Condition Management, Applied Behavioral Analysis, and Claim Fiduciary Option 1.

The following services may be carved-out in the future at APEMT's discretion at no adjustment to fees:

ACCP Enhanced Hospice Benefits Package, Informed Health Line, AbleTo network, Subrogation.

The National Advantage Program can also be carved out; the impact to the medical administration fees is a fee increase of [redacted] per-employee-per-month.

Pricing Assumptions

Your pricing considers all of the multiple products, programs and services you have with us and/or are included in this proposal and will be in effect for [redacted] months. However, as to any optional services, such services may be added at renewal or terminated at renewal. Pricing for some programs and services are amortized over a [redacted]-month period. Therefore fees will not be reduced if termination occurs prior to the end of the plan year. We require notice to properly terminate before the plan year ends in accordance with the Termination provision in your Agreement. Otherwise, you may be charged for the cost until that notice is met.

If any of the changes outlined below occur, we may adjust your Guaranteed Fees. If this happens, you'll be required to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period. If fees are adjusted, the caveats below will be based on the new assumptions.

During the Guarantee Period we may adjust your guaranteed fees and if such an adjustment is needed due to the circumstances outlined below, we will work with APEMT in good faith to negotiate the adjustment. We may adjust your Guaranteed Fees if:

1. For any product:

    a. The actual number of enrolled employees falls outside of the enrollment scenarios provided in our bracketed fee quotation, then we will work with APEMT in good faith to negotiate updated fees, and until such time, the fee in place shall remain in effect.

    b. The member-to-employee ratio increases by more than [redacted] percent. We have assumed a member-to-employee ratio of 1.95.

2. A material change in the plan of benefits is initiated by you or by legislative or regulatory action. This does not include APEMT making reasonable changes to existing benefits or adding new benefit programs in support of its business. Aetna must document the circumstances of the additional costs to APEMT's satisfaction to confirm the costs are causational. A "material" change is one which increases Aetna's cost of administration by [redacted] or more.

3. A material change in the claim payment requirements or procedures, claim fiduciary option (other than for options for which price is quoted as indicated in the Service and Fee Schedule), or any other change materially affecting the manner or cost of paying benefits is initiated by you or by legislative or regulatory action. A "material" change is one which increases Aetna's cost of administration by [redacted] or more.

4. You change or terminate the National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs.

5. There are any material changes to the programs and services we offer you. A "material" change is one which increases Aetna's cost of administration by [redacted] or more.

6. Legislation, regulation or requests of government authorities result in material changes to plan benefits, we reserve the right to collect any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated. A "material" change is one which increases Aetna's cost of administration by [redacted] or more.

If any of the conditions outlined above occur, then any performance guarantees may be changed or terminated based on the caveats outlined in those guarantee documents.

We're relying on information from you and your representatives in establishing the fees and terms of this proposal. If any of this information is inaccurate and has an impact on the cost of the programs, we reserve the right to adjust our fees and terms upon the receipt of corrected information.

Allowance(s)

- **Pre-Implementation Audit Allowance** – We're including a pre-implementation audit allowance of up to [redacted] applicable to the first Guarantee Period. These funds will be available as of the effective date of the period. Our preferred method of payment is directly to the vendor. We will pay pre-implementation audit expenses directly to the vendor only after you send us proper documentation outlining the expenses you have incurred. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. Documentation must be submitted within 60 days following the close of the plan year, otherwise you forfeit the funds. Acceptable documentation includes, but is not limited to:

  – Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent; and

  – Invoices or other documentation summarizing any other miscellaneous expenses incurred (such as travel and other business expenses related to service rendered)

  We assume the funding of any implementation budget is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. We will pay any implementation allowance in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and law.

- **Implementation Allowance** – We're including an implementation allowance of up to [redacted]. This amount requires that we are the medical vendor for [redacted] of APEMT's enrolled medical population. You can use this to pay for reasonable implementation expenses you received from third-party vendors incurred. The allowance can be used over the course of the [redacted] and we will allow payment or reimbursement in advance of the effective date to be used to pay for run-out fees or other transition related expenses.

  Our preferred method of payment is directly to the vendor. We'll pay implementation-related expenses directly to the vendor only after you send us proper documentation outlining the expenses you have incurred. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. Documentation must be submitted within 60 days following the close of the plan year, otherwise you forfeit the funds. Acceptable documentation includes, but is not limited to:

  – Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent; and

  – Invoices or other documentation summarizing any other miscellaneous expenses incurred (such as travel and other business expenses related to service rendered)

We assume the funding of any implementation budget is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. We will pay any implementation allowance in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and law.

- **Wellness Allowance** – We're including a wellness allowance of up to [redacted] per year-. This amount requires that we are the medical vendor for [redacted] of APEMT's enrolled medical population. You can use this to pay for reasonable wellness-related programs or activities you received from third-party vendors incurred during the each plan year of the Agreement. This allowance may be used for programs or activities such as wellness fairs, biometric screenings, onsite flu vaccinations, etc. These funds will be available as of the effective date of the guarantee period. We'll pay wellness-related expenses directly to the vendor only after you send us the proper documentation outlining the expenses you have incurred. Our preferred method of payment is directly to the vendor. Payment will be made once expenses are incurred and invoice(s) provided. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. Documentation must be submitted within 60 days following the close of the plan year, otherwise you forfeit the funds. Expenses must be for wellness-related programs or activities that are designed to promote the health and wellbeing of plan participants, or to educate participants about healthy lifestyles and choices. Acceptable documentation includes, but is not limited to:

  - Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent; and
  - Invoices or other documentation summarizing any other miscellaneous expenses incurred (such as travel and other business expenses related to service rendered)

  A wellness allowance of up to [redacted] is available annually. Please note, the allowance of [redacted] is available for each year and is forfeited at the end of each year if not fully utilized (it does not get rolled over for a cumulative amount).

  We assume the funding of any wellness budget is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. Any wellness-related allowance amounts we pay you directly to offset or reimburse you for any expense or costs you reimbursed a vendor for directly, must comply with these conditions. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and law.

- **Statistical Audit Allowance** – We're including a statistical audit allowance of up to [redacted]. You can use this to pay for reasonable statistical audit related expenses you received from third-party vendors incurred during the years [redacted]. These funds will be available as of the effective date of the period. Our preferred method of payment is directly to the vendor. We'll pay statistical audit-related expenses directly to the vendor only after you send us proper documentation outlining the expenses you have incurred. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. Documentation must be submitted within 60 days following the close of the plan year, otherwise you forfeit the funds. Acceptable documentation includes, but is not limited to:

  – Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent; and

  – Invoices or other documentation summarizing any other miscellaneous expenses incurred (such as travel and other business expenses related to service rendered)

  A statistical audit allowance of up to [redacted] is available in both the third and fifth Guarantee Periods, and is forfeited at the end of each year if not fully utilized (it does not get rolled over for a cumulative amount).

  We assume the funding of any statistical audit budget is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. We will pay any statistical audit allowance in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and law.

Late Payment

We'll assess a late payment charge if you don't provide funds on a timely basis to cover benefit payments and/or fail to pay service fees on a timely basis as outlined in the Agreement. The current charges are:

- late funds to cover benefit payments (e.g., late wire transfers after 24-hour request): [redacted] annual rate
- late payments of service fees after [redacted] grace period: [redacted]

We reserve the right to collect any incurred late payment charges through a claim wire billing account on a monthly basis provided there are no other special payment arrangements in-force to fund any incurred late payment charges. We'll notify you in writing to obtain approval prior to billing any late payment charges through the claim wire billing account.

We'll notify you of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

Value Based Contracting

A. Introduction to Value-Based Contracting

We have a variety of different value-based contracting (VBC) arrangements with many of our Network Providers. These arrangements compensate providers to improve indicators of value such as, effective population health management, efficiency and quality care.

B. Value-Based Contracting Models

We have VBC arrangements ranging from bundled payments and pay-for-performance approaches to more advanced forms of collaborative arrangements that include integrated technology and case management, aligned incentives and risk sharing. Our VBC models include:

Pay for Performance (P4P). Under P4P programs, we work together with providers (doctors and hospitals) to develop and agree to a set of quality and efficiency measures and their performance impacts their total compensation.

Bundled Payments. In a Bundled Payment model, a single payment is made to doctors or health care facilities (or jointly to both) for all services associated with an episode-of-care. Bundled payment rates are determined based on the total expected costs for a particular treatment, including pre- and post-treatment services, and are set to incentivize efficient medical treatment.

Patient Centered Medical Home (PCMH). In a PCMH, a primary care doctor leads a clinical team that oversees the care of each patient in a practice. The medical practice receives data about their patients' quality and costs of care in order to improve care delivery. Financial incentives can be earned based upon performance on specific quality and efficiency measures.

Accountable Care Organizations (ACOs). In an ACO, we team up with systems of doctors, hospitals and other health care providers to help these organizations manage risk, improve clinical care management, and implement data and technology to connect providers, health plans and patients. The ACO arrangements include financial incentives for the organization to improve the quality of patient care and health outcomes, while controlling costs.

We will continue to evolve our value-based contracting arrangements over time. We employ a broad spectrum of different reimbursement arrangements with providers to advance the goals of improving the quality of patient care and health outcomes, while controlling costs.

C. Value-Based Contracting Example Calculations

A customers' financial responsibility under many VBC arrangement is determined based on provider performance, using an allocation method appropriate for each particular performance program. These methods include: percentage of allowed claims dollars; number of members; percentage of member months.

Examples

1. Pay for Performance. Percentage of allowed claims dollars:
Achieving agreed upon clinical and efficiency performance goals by comparing performance year end to performance year baseline or an industry standard.
   a. Provider earns [redacted] performance-based compensation for the 12-month period January to December;
   b. All plan sponsors, combined incurred [redacted] in claims with the provider for the 12-month period January to December;
   c. Plan sponsor incurred [redacted] in claims with the provider for the 12-month period January to December;
   d. Plan sponsor's share of claims costs is [redacted]) = [redacted]. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);
   e. Plan sponsor's share of the [redacted] performance-based compensation is [redacted] * [redacted]) = [redacted], which would be processed as a claim through ordinary self-funded banking channels.

2. Patient Centered Medical Home and Accountable Care Organization. Percentage of member months:
Achieving agreed upon clinical and efficiency goals as measured by performance year end to performance year baseline or an industry standard.
   a. Provider earns [redacted] performance-based compensation for the 12-month period January to December;
   b. All plan sponsors, combined had [redacted] member months with the provider for the 12-month period January to December;
   c. Plan sponsor had [redacted] member months(for [redacted] unique members) attributed to the provider for the 12-month period January to December;
   d. Plan sponsor's share of the member months is ([redacted]) = [redacted] Formula: (Plan sponsor member months/All plan sponsors months);
   e. Plan sponsor's share of the [redacted] performance-based compensation is ([redacted]) = [redacted], which would be processed as a claim through ordinary self-funded banking channels.

3. Patient Centered Medical Home and Accountable Care Organization. Number of Members:
In addition to Example 2 above, a quarterly Accountable Care Payment (ACP) may be made to the provider to fund activities necessary to meet the financial and clinical objectives. These are paid quarterly either during, or after the end of each quarter. The financial impact is considered in the total financial package negotiated with the provider.
   a. We determine the attributed patients for the provider for the quarter April through June;
   b. Plan sponsor had [redacted] attributed to the provider for the quarter April through June;
   c. ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target;
   d. We apply the agreed upon rate to the attributed patients; i.e. [redacted] per-member, per-month (PMPM) = [redacted] per quarter per member, to determine funding to the provider;